The discussion that follows deals only with vision problems. Given the high incidence of blindness among the elderly in so many developing countries and the fact that so much of it can be prevented or cured with existing knowledge and technology, it is prevention and treatment that are focused on. Moreover, a great deal can be done in this area with relatively small expenditures of money.

B. The incidence and causes of blindness

In 1984 there were between 27 and 35 million people in the world who were blind.* The six main causes of blindness are cataracts, glaucoma, trachoma, vitamin A deficiency, onchocerciasis (river blindness) and ocular trauma. One cause stands out far beyond the rest. Cataracts are estimated to be responsible for over 50 per cent of the blindness that occurs throughout the world. 145/ Trachoma, onchocerciasis and vitamin A deficiency together account for another 35 per cent of blindness. The stark and sad fact is that more than 80 per cent of the blindness that occurs in the world today is either preventable or curable.**

C. Blindness and ageing populations

Cataracts entail a gradual loss of transparency in the crystalline lens of the eye. The result is a decline in sight capabilities (glare intolerance, misty vision and dulling of the colour sense are some of the symptoms) and, ultimately, the loss of vision (those affected may only be able to see hand movements, for instance). By far the most common type of cataract, senile cataract, is directly related to growing older; that is, most cataracts are associated with and the result of the ageing process, in ways not yet understood.

Most cataract blindness occurs after the age of 50. It is estimated that 50 per cent of persons aged 60-69 have some opacity; for those in their 80s, the incidence is nearly 100 per cent. 145/

Since the magnitude of the cataract problem and the potential blindness arising from it are directly related to the age composition of the population, the current shift to older populations throughout the world means that the incidence of cataracts will rise sharply. As discussed earlier, many developing countries are confronted with demographic ageing that is taking place much more rapidly than the ageing that took place in countries that are now developed. This has important implications for the absolute numbers of cataract-blind persons who will require attention over the next two or three decades. As developing countries age, sometimes rapidly, the incidence of blindness in the population will also rise, unless major action is taken. Moreover, in many countries of Africa and Asia, it is reported that senile cataracts appear

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*For purposes of the estimate, blindness was defined as visual acuity of less than 3/60. The estimate is reported in "Available data on blindness (update 1987)" (WHO/PBL/87.14).

**Cataracts, as discussed below, are curable; trachoma, onchocerciasis and vitamin A deficiency are preventable.

earlier than in developed countries. In Africa and Asia, many cases of cataract are appearing in people 40-50 years old; sometimes the condition appears even earlier.*

D. The restoration of vision

Until relatively recently, sight was restored to a person with a cataract by surgically removing the cataractous lens and giving the person spectacles to correct the resulting refractive error. This procedure has been developed to the point that it is a speedy, fairly simple procedure and one that is relatively safe and effective. It can be done under local anaesthesia and carried out in a variety of medical settings: eye clinics, general hospitals, "eye camps" or mobile surgical units. However, there are two drawbacks associated with the procedure. First, potential recipients must wait for surgery until the cataract has matured in both eyes, which means their lives are affected for a long time by impaired vision. Secondly, even after the surgical procedure, the patient's peripheral vision remains significantly blurred, even with corrective lenses.

There is now a newer technique known as intraocular lens implantation. This technique removes the opaque lens by microsurgery. The old lens is replaced by a plastic lens implanted behind the iris. The newer technique offers better visual rehabilitation than the older technique and does not require an optical correction with spectacles. 145/ Moreover, the newer technique has fewer short-term post-operative complications. However, in the longer term the newer technique may have to have some follow-up as it is not uncommon for there to be "secondary cortex formation and clouding of the posterior capsule". 146/ While this is not a serious matter, up to a third of the operated eyes require follow-up procedures using high-technology equipment within two years of the initial surgery.

E. The choice of technique

In developed countries, most of the cataract operationr currently use the intraocular lens implantation approach. This shift has occurred because the results are generally considered to be superior, as discussed above, and also because cost is not likely to be a serious constraint. In developing countries, the choice is not as obvious. WHO currently recommends the older approach in developing countries:

> "[The advantages of the lens implantation technique] are offset in the context of mass cataract intervention programmes by a number of disadvantages which militate against the universal adoption of ... intraocular lens implantation as a routine technique in such programmes at present.
>
> "To begin with, the change to the newer technique would require the retraining of a large number of cataract surgeons in developing countries adept [in the other procedures] ... It would also require the provision of operating microscopes, microsurgical instruments, intraocular lenses and other supplies, which are currently far beyond the reach of most developing countries.

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*It is not known why the age of onset of sensile cataract varies widely from one geographic region to another and from one climatic zone to another.

"Moreover, the greater length of time required for each [intraocular lens implantation] ... would further reduce the surgical output in terms of the number of cataract operations performed - an important consideration when dealing with the massive cataract backlog [in most developing countries]." 147/

Thus, an important public policy dilemma is arising in many countries. As populations age, growing numbers of older people will eventually become blind unless they get the needed surgery, and they will experience a devastating decline in the quality of their lives and a loss of their productive potential. The older technique for cataracts treats more people at lower cost, but the new technique produces better medical results. Should the medically superior approach be available only to those who are wealthy enough to have access to private surgeons? Are there ways to make the newer technique more economically affordable in developing countries?*

F. Policies to combat blindness

As was discussed above, among the aged the problem of cataracts reaches major proportions. In 1986, the Interregional Meeting on the Management of Cataract within Primary Health Care Systems emphasized that cataract blindness was a large and growing problem, especially in developing countries, and that the backlog of unoperated cases was rising. 148/ Given the shortage of ophthalmologists and the financial constraints in most developing countries, the Interregional Meeting also recommended that greater emphasis should be given to short training courses for specialized personnel and that innovative delivery systems should be developed to deal with the backlog of cases and the projected large-scale needs of the future. An eye care programme, including the reduction of blindness from cataract, needs to be considered by every country. Clearly, such a programme could improve the quality of life for many older people in every country.

Of course, taking effective action will be financially difficult for many developing countries. Underinvestment in blindness programmes, especially by Governments, is often the result of hard choices that must be made between saving lives by means of, say, child vaccination programmes and saving healthy days of life by, say, preventing or curing blindness. In the short run, however, it is clear that three policies could help expand the scope of blindness programmes: (a) minimizing the cost of treatment, so that financing would be easier, (b) demonstrating the need and great potential for helping people, so that international donors would support the programmes more actively, and (c) developing efficient and low-cost systems for education, evaluation and treatment systems that would be feasible in developing countries.

G. Country examples

1. India: blindness prevention and care

In the late 1970s, India adopted a national plan for the prevention of visual impairment and the control of blindness. At the time, the country was

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*WHO, for example, is currently experimenting with alternative materials for suturing that could dramatically reduce the cost of this important medical supply for the new microsurgical technique.

faced with a staggering problem of blindness: 9 million people were blind and 45 million were visually impaired. To deal with the problem, there were only 3,800 eye specialists and 2,000 eye assistants in the whole country.

The National Programme for Control of Blindness launched by the Government of India sought to dramatically expand the number of trained personnel, to use the mass media to educate more people about eye care, to extend services by means of mobile units and the creation of "eye camps" and to establish eye care facilities as an integral part of general health services at the local, state and national levels. 149/ The main objective of the Programme was to deal with the tremendous backlog of patients having operable cataract conditions.

Over a 10-year period, 9.5 million cataract operations have been performed in India, a tremendous achievement. Unfortunately, as growing numbers of people in the country enter the age 40+ cohort, the challenge has grown rather than diminished. A 1986-1988 survey, carried out with the help of WHO, found that despite exceptional efforts there were still 12 million persons who were blind in both eyes and another 8 million blind in one eye, with cataract blindness accounting for 81 per cent of all these cases. In addition, the survey found that there were 52 million "immature eyes" and another 18 million incipient cataract eyes.

Given these discouraging statistics, there has been continued attention to finding ways of treating greater numbers of people. A pilot project in Madhya Pradesh was started in 1988 to test a cataract-free-zone approach that seeks to identify and treat all mature and hypermature cataract cases in a specified geographic area. Good results are reported from this project. 150/

There have also been a number of non-government initiatives in India. One of these is the work of the Blind Men's Association in Gujarat State. The organization, founded in 1950 as a recreational club for the blind, gradually shifted its attention to combating the stereotypical notion that blind people were helpless objects of charity who could not acquire the skills needed to become productive members of society. In 1983, the founder of the organization, Jogdish Patel, launched a programme to rehabilitate blind people, using methods that have proven themselves effective over the years. Special attention was given to unmet needs in rural areas.

In carrying out this programme, a geographical area, such as a cluster of villages or a slum area of a city, is chosen. In the area, the programme seeks to be comprehensive in nature, offering all types of medical care, social activities and economic rehabilitation. 20/ High priority is given to medical needs. The aged blind and disabled in the designated area are screened by the organization's staff and volunteers. When the situation warrants, individuals are sent to the biggest city in the State, Ahmedabad, to receive special treatment. Eye clinics are held regularly in various village or community schools, and an effort is made to involve the whole community. Cataract operations are performed at these clinics.

According to HelpAge International, 151/ at the end of two years, the organization team withdraws from an area. This withdrawal is regarded as a positive action and not as an abandonment of the people or the vision programme. It is a principal objective of the programme to enable the elderly people to look after themselves in so far as possible, getting what support they need from their community. Moreover, the team is available in some other

part of the region and can be contacted, if needed, by the village. Also, before leaving the village, the team lays the basis for future work by building up a small fund that can be used locally to respond to emergency needs.

2. Belize: a non-governmental organization fights blindness

About 1 per cent of the population of Belize, many of them elderly, are either blind or visually impaired. As is often the case in developing countries, Belize lacks the public finances and services needed to deal with the problem in a significant way. However, a private voluntary foundation has stepped in and has launched a small but innovative programme to help those already blind and to prevent even greater numbers from losing their sight in the future.

The Belize Council for the Visually Impaired was founded in 1981 by a group of concerned Belizeans who saw an urgent need for assisting the blind and preventing blindness. At present, the Council is the only organization in Belize offering a wide range of services for the blind:

(a) A blindness prevention programme, including eye clinics; vision screening in schools; the distribution of eye medications and spectacles; referral services; and workshops and training;

(b) A public awareness programme, providing radio programmes on vision care and eye problems; radio spots on the needs and rights of the blind; information pamphlets; and newspaper articles;

(c) A rehabilitation programme, which engages in the following:

(i) Training the blind to be more mobile and to develop their daily living skills;

(ii) Counselling the newly blind and visually impaired;

(iii) Running a social club that brings together the housebound elderly who are visually impaired;

(iv) Training community volunteers to assist blind people;

(d) An education programme that gives classes in Braille; helps the blind with access to schooling; supports services for blind persons going to school; and provides Braille materials.

Even with a small staff of professionals, supported by volunteers, the programme has been able to regularly test hundreds of children and elderly people and provide them with medical services and/or spectacles. However, the programme is currently concentrated within and on the outskirts of Belize City and does not reach the 75 per cent of the population living in the rural areas.

The financial resources for the programme have come from many sources: the international aid programmes of foreign Governments, HelpAge International, the Red Cross, the Government of Belize, the International Eye Foundation, the Christofel Blinden Mission and Missionary Optical Supplies. Recipients of services are also asked to pay what they can. However, the main source of funding in years past has been the Caribbean Council for the Blind.

The overwhelming majority of people who suffer from serious vision problems are likely to be in the middle or later years of life. As soon as their eyesight begins to fail, these people are seen as a liability to the nation rather than an asset. The Council programme tries to help those most in need and seeks to pave the way for a comprehensive national vision programme in the not-too-distant future.

3. Malawi: the blindness prevention programme

Preventable and curable blindness is a serious public health problem in Malawi. Between 0.8 and 1.0 per cent of the population is affected, with 40 per cent of the cases attributable to cataract. 152/ In 1979, F. H. Budden estimated that there were about 60,000 blind persons in a country of about 6 million people. 153/

In 1979, the Malawi Council for the Handicapped, in collaboration with the Ministry of Health, established the Prevention of Blindness Committee. The Committee seeks to promote the interdisciplinary study of ophthalmic problems and to monitor the country's planning and programme efforts.

The Blindness Prevention Plan of Action was established by the Ministry of Health for the 1982-1987 period. The Plan called for integrating blindness prevention activities with the general health service. It also called for training, supervision, support and referral services, extending from the communities to the hospitals. Targets and strategies were established to reduce blindness and visual impairment in general. 154/ It is hoped that the following targets will be reached by 1993.

(a) Community workers, such as nurses and medical assistants, will be trained in the recognition, treatment or referral of cataract, trachoma and xerophthalmic cases;

(b) District hospitals will have at least one ophthalmic medical assistant;

(c) Ophthalmic clinical officers will be trained in cataract extraction and posted to designated district hospitals;

(d) Most children will be treated with tetracycline ointment and receive vitamin A capsules;

(e) A programme of health education will reach most health workers and mothers.

Currently, the focus of the programme is to extend eye care services to rural communities. Mobile eye units, staffed by ophthalmic assistants, play an important role in reaching rural people. They provide treatment, education and referral services. Before doing anything else, the personnel of the mobile unit give a lecture on preventive ophthalmology and primary eye care to the local inhabitants. Then, patients with acute eye problems are treated. Those with serious problems are referred to the district or central hospital. Blind persons are registered and advised on how to go about attending either the vocational training school or the blind schools run by the Malawi Council for the Handicapped.

VII. HOUSING FOR THE ELDERLY

Adequate housing is an important issue for all age groups. It is particularly important, however, for the elderly, because their housing needs change: not only do children leave, family members migrate or spouses die but also economic circumstances often change, largely because of declining employment opportunities. Most importantly, as people age their health changes significantly, often dramatically affecting the suitability of their existing housing arrangements and their future needs.

In the face of these changing circumstances, many important housing issues arise. One such issue is the nature of special programmes and policies to meet the housing needs of older people and the extent to which they should be emphasized. It is rare to find a country where there are not serious shortages in adequate housing for the population as a whole, and national efforts to make up these shortages are widespread. Inevitably the special needs of the elderly compete for scarce resources with the needs of others. In this context, countries must decide on the extent to which they can respond to the often rapidly changing and very real housing needs of older persons.

A. Stability with choice

The proportion of older people living in an independent or separate housing unit is relatively high in developed countries; in developing countries, joint living arrangements predominate. Studies of housing patterns among the elderly find, not surprisingly, that the tendency among older people is to remain in place. 155/ That is, there are fewer shifts in living accommodations among older people than among younger people. A study in France found that older people move only half as often as younger people. 156/

A change of residence by an older person, when it comes, is usually the result of a variety of personal and environmental events. These include (a) deteriorating health and functional disabilities, (b) diminished economic resources, (c) the declining quality of structures, neighbourhoods or the general environment, (d) changing housing options available upon retirement, including amenity moves arising from the individual desire to enjoy a new area, a warmer climate etc. and (e) moves motivated by the migration of children or other relatives.*

There is now much evidence available in the field of ageing to show that most elderly people want to avoid long-term placement in institutions such as hospitals, nursing homes and old age homes. At the same time, there is a growing interest among older people throughout the world in independent living arrangements and a variety of new retirement-living settings, to the extent that economic circumstances permit.

There is no one type of housing that is best for the elderly. Because individual circumstances vary so greatly, even in a single country, and are so liable to change with time, there is a need for choice. That is, each country should seek to provide its people with a variety of living situations that are responsive to their changing circumstances. Other elements of housing policy that are especially relevant to elderly populations are as follows: (a) the

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*For one suggested topology of moving, see Wiseman. 157/

provision of appropriate neighbourhood amenities and support services, (b) the avoidance of arrangements that encourage overdependency and (c) the promotion of housing adaptable to changes over the life-cycle.*

Instead of surveying the entire range of housing types and the environmental/service issues associated with each type, this section focuses on a single issue that has been important but controversial over the years: age-segregated housing.

B. Age-segregated housing

One of the many questions that arises in relation to housing is the extent to which public policy should encourage or act to create special housing for the elderly that is age-segregated. Experience in some countries shows that a significant proportion of the elderly find it desirable to move at some point to housing built exclusively for older people. The range of alternatives extends from the housing units that allow independent life-styles in retirement villages and towns in some of the developed countries, to apartment houses for older people providing minimal special services, to sheltered rooms and apartments for the elderly, with communal eating facilities and other sponsored support services. A more detailed discussion of the various alternatives can be found in Eckert and Murrey. 159/

There is little controversy over the need for specialized institutions, such as nursing homes, for those elderly needing extensive assistance but who have no relatives to care for them or for those elderly who are seriously ill and require special medical care. Nor would many disagree with promoting intergenerational family living arrangements that strengthen reciprocal support mechanisms and provide care for older persons when they become ill, physically incapacitated or economically vulnerable. Rather, the controversy centres on whether independent living arrangements that provide alternatives to family care should be promoted and, more generally, whether age-segregated facilities are in the long-term interests of the aged and society in general.

M. Powell Lawton, relying heavily on research carried out in the United States and citing Messer, 160/ Rosow 161/ and Lawton, 162/ writes that "past studies have shown that clear social gains have been associated with age homogeneity. And recent research shows that while the majority of elderly people do not wish to live in age-segregated housing, a substantial minority (about one third) prefer to live exclusively with other elderly people". 163/ Moreover, studies show that those who choose this style of living in later years tend to increase their friendship circles, have better relationships with their families and have an improved self-image of themselves as older people. In contrast to integrated settings, where the standards and expectations of younger people tend to prevail, homogeneous settings promote the emergence of a distinctive and more appropriate set of norms, which is of more relevance to the elderly. (See, for example, Carp, 164/ Hamovitch, 165/ Bultena and Wood, 166/ Teaff and others 167/ and Silverman. 168/)

However, a shift to any new living situation can be emotionally and physically debilitating. A move to special housing is very likely to involve

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*A somewhat similar list of objectives is presented and discussed in Pynoos. 158/

a geographic shift away from one's community and friends of many years. Often, the special housing, especially in larger complexes, is located in isolated areas, owing to financial constraints and the availability of existing buildings or land.

Moreover, some critics of age-segregated housing argue that it promotes isolation from the broader community and encourages dependency among the elderly. Where support services are provided, "... the more competent may become reduced to the point where their skills are not sufficiently exercised. For example, a study of 'warden housing' (housing with a live-in caregiver) in England found that tenants in this type of housing used more services than people of comparable health not living in housing with wardens". 169/ The study of warden housing is reported in Tinker. 170/

Thus, a great deal of controversy remains over the extent to which age-segregated housing should be promoted. At the same time, it is also true that in many countries this type of housing continues to grow, often rapidly.

C. Non-institutional housing for the elderly

There is now a wide variety of non-institutional housing explicitly designed or designated to serve the elderly. Of course, it is sometimes difficult to draw a distinction between institutional and non-institutional settings. However, as Goffman, 171/ Barton 172/ and Townsend 173/ have discussed in their well-known books on the topic, the common features of institutional life are regimentation, depersonalization and social distance.* Clearly, many special housing options now exist for the elderly that in large part avoid these institutional problems. These include retirement villages or communities, life-care communities, sheltered or congregate housing (*logement-foyers* in France), granny flats, foster homes, shared housing and group homes. The choices and options exist; it remains for each country to have housing policies appropriate to its particular situation.

D. Country examples

1. United Kingdom: group housing

The potential for group housing is well illustrated by the network of houses operated in the United Kingdom by the Abbeyfield Society. The majority of these houses are traditional one-family houses in established residential neighbourhoods, accommodating six to eight "able-bodied but lonely" residents; some houses, however, have been specifically designed and built by Abbeyfield for group living. The typical arrangement provides each resident with a

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*As Goffman writes with regard to institutional life: "Firstly, all aspects of life are conducted in the same space and under the same single authority. Second, each phase of the members' daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same things together. Thus, all phases of the day's activities are tightly scheduled, with one activity leading at a pre-arranged time into the next ... Finally, the various enforced activities are together into a single rational plan, purportedly designed to fulfill the official aims of the institution." 174/

private bed/sitting-room, in which he or she can put his or her own furniture. Each room has a hotplate for preparing hot drinks and breakfast. In addition, there are common areas in the house, including a dining-room, where the residents come together for the two main meals of the day. A live-in housekeeper shops, prepares meals, supervises providers of domestic and support services who come in on a daily basis and acts as a house-mother for the residents.

Thousands of volunteers undertake financial supervision, management, planning, fund-raising and social work for the Abbeyfield homes. These volunteers, with support from the community and sometimes from the Government and in line with the programme's emphasis on simplicity of design and organization, have helped to keep the costs of the living accommodations low. Each home is financially self-supporting, and residents are expected to pay their own way. However, charges are kept to a minimum and, where possible, within state income support levels, ensuring that the housing is affordable for most elderly people.

Special efforts are made to avoid setting up the houses in isolated locations; they are generally near shops and the everyday activities of the community. One important goal of each house is to make it easy for people to avoid the loneliness that is all too often a problem of growing older, while retaining their dignity and independence.

By 1990 the Abbeyfield programme comprised about 600 largely autonomous local societies managing over 1,000 houses. These houses accommodate almost 9,000 elderly people. The average age of the residents is about 84 years.

A number of issues have arisen in connection with maintaining and improving the Abbeyfield programme, including the following:

(a) A desire, as the physical and mental capacities of residents change, to minimize the potential trauma of residents having to move to a higher care facility. The original Abbeyfield concept did not provide for greater care as people's needs changed. Recently, however, Abbeyfield has opened a number of extra-care houses throughout the country with round-the-clock support services and is also exploring building options that would combine the original residence concept and extra care in one facility;

(b) Concern over possible future shortages of active, committed volunteers and possible difficulties in finding housekeeping and care staff;

(c) Difficulties in projecting the future demand for this type of housing, given changing demography and the growth of alternative types of special housing for the elderly, both public and private.

Abbeyfield came into being because one man, Richard Carr-Gomm, came face to face with the sheer desperation that loneliness and isolation can inflict on the very old. He decided to do something about it and purchased a house to provide shelter for four elderly people. This was the first Abbeyfield house. In a presentation to the Aging Pre-Conference for the XIVth International Congress of Gerontology at Acapulco, Mexico, from 19 to 23 June 1989, a spokesman for the Abbeyfield Society said, "Because the idea was so simple, because each scheme [was] so compact and manageable and because the need was so great, the idea caught on."

Abbeyfield International was set up subsequently to spread the idea worldwide.* Countries with active programmes now include Australia, Canada, Ireland, Italy, the Netherlands, South Africa and the United Kingdom.

2. United States: retirement communities

In the early 1980s, almost 1 million people in the United States lived in retirement villages or communities. 175/ These retirement communities have been formally defined by Webber and Osterbind as small communities, "relatively independent, segregated (by age) and noninstitutional, whose residents are mainly older people separated more or less completely from their regular or career occupations in gainful or nonpaid employment". 176/ Basic maintenance and repair services are provided for a fixed monthly fee. Available within the community are a variety of recreational and social activities, transportation to stores and/or community shops and certain health services.**

Between forty and fifty years ago, when the first communities were started, they were typically small. Today there are retirement communities with thousands of houses and resident populations of 20,000 to 50,000. Geographically they can be found in all regions of the United States but tend to be concentrated in the states of California, Florida and Arizona, where the climate is usually moderate, sunny and warm.

Three types of retirement community have been delineated by experts.*** Most planned retirement communities have been started by private real estate developers or investor groups. These entrepreneurs seek to profit by selling or renting retirement housing units to relatively younger and more active old people seeking this particular type of living situation. Emphasis is usually on a wide range of social and recreational activities. Communities often have activity centres, swimming pools, tennis and/or golf facilities and open spaces reserved for biking, jogging and walking. "Retirees move to retirement communities not only because they want housing but because they want a life style that encompasses the community as a whole - a life style devoted to retirement living." 179/

Personal security is another factor that attracts people: many retirement communities have definite boundaries, limited access through gates and security guards. Moreover, the residential setting makes it relatively easy for those living there to be aware of outsiders and encourages people to provide mutual protection.

A second type of retirement community is the continuing care retirement community (CCRC). These communities explicitly include arrangements for different levels of health care, services that were not traditionally associated with the first planned retirement communities. The earliest CCRCs typically required a person to pay an endowment or entrance fee in return for

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*The address of Abbeyfield International is 186-192 Darker Lane, Potters Bar, EN6 1AB, United Kingdom.

**The differences between planned and unplanned communities are discussed in Webber and Osterbind. 177/

***The three types are discussed in Streib. 178/

a guarantee of life-long care. Some CCRCs still require a large entrance fee, and almost all require a monthly fee that may depend on the services being received.

"Naturally occurring retirement communities (NORCs) were not designed as retirement communities, but they are areas that attract a large proportion of older people because of various reasons - climate, natural recreation assets, costs or rural nature." 180/ Such communities do not have the clearly defined organizational and geographic boundaries associated with the other two types. Their structure is usually less formal and less restrictive.

For retirement communities to be financially viable over the long run, planners have stressed the need to maintain heterogeneity of ages within the existing age restrictions (typically, people under age 50 are excluded).* Concern arises that, as the originally younger residents grow older, the community will consist mostly of the very old and that the middle-aged and the "young" old will not be willing to buy units that become vacant. Streib, La Greca and Folts point out that "most residents are unconcerned about the economic viability of a community until a crisis situation arises, and this may be too late for the residents to have an input into the decision-making process". 181/

Retirement communities continue to be very popular in the United States among a significant minority of the elderly. They provide a physical and social milieu that is responsive to the retirement needs and interests of many older people with increased leisure time and financial independence. Streib, for example, concludes from studies of this unique housing option that "those who move to retirement communities are very satisfied with the life-style they have chosen". 182/

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*A few communities have units for younger age groups.

VIII. THE DEVELOPMENT OF AN INFRASTRUCTURE FOR AGEING

It is only quite recently that the world became aware of the demographic ageing of nations and began to recognize both the opportunities and the problems associated with growing numbers of older persons. Thus, the history of action programmes, research and training in ageing is relatively short; in many countries it hardly exists at all. The reality in most nations is a small but typically scattered core of advocates and experts in ageing who seek to expand their nation's awareness of ageing issues and promote specialized activities related to the older segment of the population. One important matter that arises, therefore, is deciding on appropriate ways to create what might be called an ageing infrastructure that can respond to demographic changes and the social, economic and political implications of a growing elderly population.

A. Organizing those interested in ageing

People interested in issues of ageing, and this group includes people of all ages, are likely to feel isolated and on the defensive in most countries. Since their interests are not likely to be shared by many others, it is difficult for them to find people with whom they can interact in a positive way. And because issues of ageing are nearly always far down on the list of community, regional and national priorities, these people frequently find themselves having to defend their interests in ageing policies and programmes. Moreover, they are apt to find the community as a whole, and the political leadership serving it, quick to turn a deaf ear to requests for attention, resources or planning to benefit the elderly.

An obvious but fundamental first step is for those with a common interest in ageing to find one another and to take action that will expand the number of concerned citizens. Meetings need to be organized at the local, regional or national levels. The focus can be on sharing knowledge, information or concerns about the ageing situation; on sharing personal experiences; or on discussing community programmes or issues arising out of individual or collective interaction with older people in the community. Alternatively, individuals can meet to discuss and assess government programmes and policies that affect the elderly, for example, in the area of health services or to plan ways of addressing the specific needs of older people, perhaps seeking ways to set up a pilot project to demonstrate the efficiency of some new approach.

These and many other good reasons for a meeting provide the basis for bringing together people with a common interest in ageing. Out of such meetings are likely to come plans for various kinds of collective action: the creation of formal ageing organizations, the planning of community activities to collect information about the aged, the raising of funds for activities to benefit the aged, the creation of elderly support programmes, the making of recommendations to Governments etc. While the initial impact of the meeting may be rather minimal, the important thing is that such a meeting, and any activities that may follow, helps to create a bond among those involved and is likely to encourage those who are interested in issues of ageing but who feel isolated and discouraged.

Once core groups of individuals come together in various parts of the country, it will be easier to broaden the awareness of ageing issues in the country at large. Tout, for example, suggests one approach to furthering this objective when no formal structure exists within a country:

> "The first meeting should be fairly unambitious and should concentrate on causing people to consider their own community and recognize the signs of a greying population ... It is at this stage that the external advisor can be particularly useful, outlining possible initial organization and activity as well as counselling against the inevitable well-intentioned but over-ambitious plans which tend sometimes to spring from initial discussion, only to disappoint at later reviews.
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> "At this point it may be possible to agree on a regular group meeting, with one or two honorary officers, but not too complex a structure." 183/

Ultimately, of course, it will be possible to form larger, more visible and politically more significant groups.

As the number of people interested in ageing issues increases, and with it the number of activities, a variety of broad-based organizations will emerge. These include such organizations as gerontological societies, geriatric groups, organizations of older people, educational associations, national councils, research institutes, federations of service delivery organizations and national committees on ageing.*

B. The need for an information base

It is very important for individuals and groups interested in ageing to develop and support, in their very early stages, mechanisms for creating an information base that will be helpful in future discussions and planning. In addition to collecting and synthesizing information that already exists at home and abroad, groups will want to initiate the collection of new data, ranging from modest interview surveys in local communities to university-based, multidimensional projects. Information is needed in each country on demographic trends, the socio-economic characteristics of the aged population, the nature of formal and informal mechanisms for providing services, the existence of service gaps, the effectiveness of on-going activities and policies that significantly affect the older population, the social relationships between the elderly, their families and other people and attitudes and practices related to elderly work and retirement.**

It is not enough, however, for ageing groups to broaden their own knowledge about the situation of the aged in a particular country. It is important to also inform national leaders and the community at large. People are not generally likely to be aware of the extent to which demographic ageing is occurring, since almost everywhere it is a relatively recent phenomenon. "Locally, the increment of people surviving to an older age will thus still

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*For a listing of 270 organizations and educational institutions throughout the world, see United Nations. 184/ For a compilation of research and researchers, see Nusberg and Sokolovsky. 185/

**For an excellent, up-to-date overview of the various aspects of ageing research, see The Handbooks of Aging, 3rd ed., published by Academic Press in 1990. The handbooks are published in three volumes: Handbook of the Biology of Aging, Handbook of the Psychology of Aging and Handbook of Aging and the Social Sciences.

be almost imperceptible. Likewise, although the populace may be aware of the incidence of migration, this may not have been related in people's thinking to the increasing number of old people whose sons and daughters have left the aged parent living alone. The first stage in any community reaction is therefore some awakening of awareness to the incipient social problem". 186/

Various means should be considered for informing leaders and the general public: informational pamphlets, research reports, local meetings, interviews and stories to the media and direct discussions with ministry officials and political leaders, to name a few. Often the launching of a new project for the elderly provides an effective way to attract attention and inform people. For example, the recycling programme started at Pereira, Colombia (see part three, chap. I.D) serves not only as a reminder that many older people want and need to work. It also shows that many of them can still work hard, that they care about the environment and that they can contribute positively to the solving of community problems if given the opportunity.

Another important aspect of activities related to the information base is training. As knowledge about ageing affairs grows, it will be necessary to develop formal mechanisms for educating the individuals, both paid and volunteer, involved in ageing activities. While training can take many forms, the basic objectives are to put day-to-day activities into a broader context, to improve skills, to exchange experiences, to enhance sensitivities and to strengthen both the involvement and commitment of these individuals.

C. National committees

Many countries have established a national committee on ageing as a mechanism for providing the Government with information and advice. Often, too, a national committee is charged with assisting in the coordination of activities related to ageing throughout the country.

In November 1987, the United Nations Office at Vienna, Centre for Social Development and Humanitarian Affairs, sent a questionnaire on the status of national machineries on ageing to all Member States. It was found that there were 84 national machineries on ageing in existence. Of these, 49 were national committees with broad institutional bases and 35 were focal points, that is, single offices or officials responsible for questions of ageing in a particular State. Of the 49 national committees reporting, 29 were in developing countries. Thirty-two were governmental bodies, three were non-governmental and four were a combination of the two.

It is generally recommended that national committees include representatives of (a) the Government, (b) non-governmental organizations and (c) organizations of and for the elderly themselves. The survey by the Centre for Social Development and Humanitarian Affairs found that organizations of the elderly were represented on 23 national committees, 14 of which were in developing countries. Government planning bodies were represented on 20 national committees, 11 of them in developing countries. The activities undertaken by these committees are diverse: 42 are involved in policy formulation; an equal number participate in programme implementation; 30 engage in or initiate research; and 23 undertake training-related activities.

D. International exchange and cooperation

Individuals and groups interested in ageing can benefit from an exchange of information and activities with individuals and groups in other countries

and with international organizations. Countries vary greatly in their experience and the progress they have made in dealing with ageing issues, so that the cross-country sharing of experiences, comparative assessments of programmes and activities and the exchange of research findings are all useful. Attendance at international meetings on ageing is one of the most common ways of promoting this objective. Such meetings not only provide information but also facilitate contact with counterparts in other countries. The International Congress of Gerontology, sponsored every four years by the International Association of Gerontology, is probably the largest and best-known global meeting held on a regular basis. New research findings are the main focus of the Congress, but policy and planning discussions regarding ageing issues are also on the agenda.

Study tours to other countries have been found to be a very effective way of establishing contact with people and organizations abroad and of learning about how issues are addressed in other countries. While such study tours can be general in nature, they are often more effective if they focus on a relatively narrow and well-defined concern.

Many countries have set up formal exchange programmes with institutions in other countries. Frequently, an institution of higher education in one country will negotiate an agreement to periodically exchange faculty, students and publications with a similar institution in another country. Sometimes collaborative research projects are undertaken with national or international funding.

The United Nations focal point on ageing, the Centre for Social Development and Humanitarian Affairs, serves as an important resource for many countries. In addition to promoting implementation of the International Plan of Action on Aging, endorsed by the General Assembly in its resolution 37/51 of 3 December 1982, the Centre responds to requests for information from various countries; it coordinates the exchange of information within and between global ageing networks; it publishes the Bulletin on Aging, global directories and a variety of other informational materials; it sponsors international meetings; it evaluates and monitors projects of the Trust Fund for Aging; it drafts reports of the Secretary-General on the subject of ageing to United Nations bodies; and it gathers information and carries out research on topics of international significance.

E. Country examples

1. Singapore: building an ageing infrastructure 112/

During the 1980s, the Government of Singapore, increasingly concerned about the growing proportion of older people, set up a number of committees to study the situation, trends and issues that needed to be addressed. These efforts began in 1982 with the appointment of the high-level 13-member Committee on the Problems of the Aged. The Committee, which was chaired by the Minister of Health, not only looked at humanitarian and social welfare concerns but also sought to explore the potential contributions of the elderly to Singapore society and its socio-economic development. To help it in its deliberations, the Committee commissioned a national survey on senior citizens, which was carried out in 1983. The survey was based on 5,538 persons age 55 and over who were living in private households. It updated information from an earlier survey in 1976.

The Committee on the Problems of the Aged made many recommendations, most of which were accepted by the Government. To implement them, several additional committees were established. Their members were drawn from ministries, statutory boards, institutions of higher learning and non-governmental agencies. In addition, the Committee on Public Awareness on Aging was set up to spearhead a public education effort, and the Task Force on the Employment of the Elderly, which included representatives of employers, unions and the Government, was set up to study the need for counselling and/or retraining elderly workers.

Recognizing that the ageing population is a demographic issue, the Government established the Inter-Ministerial Population Committee in 1984. This Committee was asked to undertake a comprehensive review of Singapore's population trends. Particular attention was given to Singapore's declining fertility rate and the measures that might be taken to bring about the desired population size and composition. After reviewing the recommendations of the Inter-Ministerial Population Committee, the Government revised its population policy in 1987 and asked the Committee, assisted by the Population Planning Unit, to monitor Singapore's evolving population trends.

A significant step, the establishment of the Advisory Council on the Aged, was taken in 1988. Headed by the Minister for Home Affairs, the Council was asked to undertake a comprehensive review of the status of the ageing in Singapore. One of its key recommendations was that a national council on ageing should be set up to plan and coordinate policies and programmes for the elderly.

With the encouragement of the Government, senior citizens' clubs have proliferated. These clubs offer recreational programmes, health screening, fitness activities and opportunities for community service. At present there are 166 clubs with a membership of about 48,000 older people. They are run mostly by the Government or by paragovernmental organizations. Of the few clubs not operated by the Government, the Singapore Action Group of Elders is the largest, with about 1,500 members.

Singapore has been active in regional and international meetings on ageing and has participated in a number of international research projects. For example, from 1984 to 1988, a regional ageing project of the Association of South-East Asian Nations was launched, with Singapore as the principal coordinator. A comparative study of four countries, including Singapore, on social change and ageing was launched in 1989.

2. China: responding to the challenges of population ageing

Of all countries, China has the largest number of older people, about 66 million aged 65 or over in 1990. 187/ However, the proportion of the population that is old was relatively low, at least until recent years. A series of major population planning programmes have been promoted since 1949. The most significant, the one-child campaign begun at the end of the 1970s, was designed to sharply decrease the growth of the Chinese population. The resulting decline in fertility in many parts of China will lead to an increase in the proportion of the population that is old.

By the year 2000, persons aged 65 and older are projected to account for 7 per cent of China's population. After 2000, the elderly population will increase rapidly and is projected to rise to about 35 per cent of the total

population in 2035. 188/ If this increase occurs, it will be the most rapid demographic ageing ever to have taken place anywhere.

China has relied heavily on, and encouraged, the traditional support of older people by their families. However, the Government realizes that population shifts resulting from population planning policies will make it more difficult for families to provide the needed support. As a result of the one-child policy, for example, there will be fewer siblings, a smaller number of relatives, i.e. uncles and aunts, and a thinning out of consanguineous relationships. The reduced size of the extended family is seen as likely to weaken the family network, which has been, and still is, the main pillar of old age support in China. Accordingly, the Government is increasing its attention to ageing issues and the need to develop an infrastructure for ageing.

The growing importance of ageing issues was signaled in 1983, when the Government established the China National Committee on Aging. The Committee is composed of 13 government organizations, 4 social organizations, 2 news agencies and 1 research institute. In addition, it has regional committees in all the provinces and in three large cities. The Committee has a certain amount of independent authority within the Government, but regular progress reports and important ageing issues must go before the State Council, which takes the final decision. As Philip Olson describes it:

> "The Committee, though not an arm of the government, is a barometer of the intent of the state and Party in its concerns for the aged ... The Committee is making visible the Party concerns for the aged by encouraging the formation of aging committees at all levels of government, including provincial, municipal, district, and in street and residents' committees." 189/

Initially, the Committee has had several tasks:

(a) To develop an awareness and concern for the aged throughout the country;

(b) To gather information about the problems of older people and their possible solutions;

(c) To formulate policies and principles and make recommendations on ageing issues to the State Council;

(d) To organize international ageing conferences and encourage cooperative exchanges with other countries;

(e) To encourage the development of ageing committees in the provinces, municipalities and autonomous regions;

(f) To help coordinate actions related to ageing among various governmental organizations;

(g) To gather information on how ageing issues are addressed in other countries;

(h) To promote, in cooperation with the Ministry of Civil Affairs, the setting up of old age homes, universities for the elderly and voluntary in-home nursing care.

Research on ageing has been increasing in China. A sample survey of 36,755 individuals over age 60 was carried out in 1987. There are at least 10 population research institutes; among their concerns are the changing profile of the elderly population, its regional distribution and the projection of its changing size. 190/ Major research on policy is under way to develop a Chinese social security system, with experiments taking place in different parts of the country. Research on ageing is also conducted at the Chinese Academy of Social Sciences, the Beijing Academy of Social Sciences, the Shanghai Academy of Social Sciences and at other research institutes in several other large cities. The Chinese Association of Geriatric Medicine was approved by the All-China Medical Association, and geriatric research and service units have been established throughout the country. The China Association of Gerontology has been created to promote discussion and research on issues related to ageing, and gerontological associations have also recently been formed in Shanghai, Harbin, Beijing and Tianjin.

An offshoot of this interest is the dozens of monthly magazines devoted to ageing in China. Of these, Chinese Elderly, the magazine of the China National Committee on Aging, has the largest circulation. There are, as well, two national weekly newspapers and one Shanghai newspaper that focus on ageing.

In an interview that took place in 1985 at Beijing, Wu Yuanjin, the former Secretary-General of the China National Committee on Aging, articulated the main goals of the ageing infrastructure being developed in China as follows:

(a) To provide general support to elderly people in China;

(b) To help them reach their full potential;

(c) To provide them with opportunities for further education and study;

(d) To help meet their need for financial and other support;

(e) To promote their participation in community activities;

(f) To ensure that everything possible is done to make their final years as happy as possible.

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